



1942 State Street
 Hamden, CT 06517
 877-DR-STUFF
 or 203-785-8475
 FAX: (203) 785-8704

FAX COMPLETED FORM TO:
 (203) 785-8704

SECURE TAMPER RESISTANT ORDER FORM

Please Print Clearly

Practice Name _____

Address _____ Phone # _____

Contact _____ Fax # _____

City _____ ST _____ ZIP _____ PO# _____

E-mail address _____

Prescriber Information (as you want it to appear on the form)

*Required Field

Clinic or Business Name _____

*Prescriber Name _____

Specialty _____

*Address _____

*City, State, Zip _____

*Phone # _____ *License# _____ DEA # _____

(If no DEA # is provided, we will leave a blank space for it to be written in)

Enter Additional Prescribers on Page 2

Total # of Prescribers _____

Total # of Addresses _____

Security features included are compliant with federal guidelines for the following states:

AL, AK, AZ, AR, CO, CT, DE, GA, HI, ID, IL, IA, KS, LA, MD, MA, MI, MN, MS, MO, MT, NB, NV, NH, NM, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WI

Please call for order information if you are in:

CA, FL, IN, KY, ME, NJ, WV, WY

Lead time: 5-7 days after order approval

Doctor Stuff Secure Prescription Program

1942 State St. • Hamden, CT 06517

Phone: 877-DR-STUFF • Fax: 203-785-8704

Pad Product Options:

- 4-1/4" w X 5-1/2" h (Vertical)
- 5-1/2" w X 4-1/4" h (Horizontal)

Each pad contains 100 sheets

Quantity:	Pricing
<input type="checkbox"/> 10 pads	\$ 89.00
<input type="checkbox"/> 20 pads	\$ 119.00
<input type="checkbox"/> 30 pads	\$ 169.00
<input type="checkbox"/> 40 pads	\$ 179.00
<input type="checkbox"/> 50 pads	\$ 219.00
<input type="checkbox"/> 60 pads	\$ 239.00

ADDITIONAL PRESCRIBERS

Note: you are allowed up to 3 prescribers on a sheet . If you do not want the practice name, you allowed up to 4 prescribers.

Please Print Clearly

Clinic or Business Name _____

*Prescriber 2 Name _____

Specialty _____

*Address _____

*City, State, Zip _____

*Phone # _____ *License# _____ DEA # _____

(If no DEA # is provided, we will leave a blank space for it to be written in)

*Prescriber 3 Name _____

Specialty _____

*Address _____

*City, State, Zip _____

*Phone # _____ *License# _____ DEA # _____

(If no DEA # is provided, we will leave a blank space for it to be written in)

*Prescriber 4 Name _____

Specialty _____

*Address _____

*City, State, Zip _____

*Phone # _____ *License# _____ DEA # _____

(If no DEA # is provided, we will leave a blank space for it to be written in)

Other ordering information: _____